The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see [https://www.smith.edu/about-smith/hr/benefits](https://www.smith.edu/about-smith/hr/benefits). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [bluecrossma.org/sbcglossary](http://bluecrossma.org/sbcglossary) or call 1-800-782-3675 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>No.</td>
<td>You will have to meet the deductible before the plan pays for any services.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. $100 member / $200 family Rx deductible applies.</td>
<td>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$2,500 member / $5,000 family.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://bluecrossma.com/findadoctor">bluecrossma.com/findadoctor</a> or call the Member Service number on your ID card for a list of network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Primary care visit to treat an injury or illness</td>
<td>In-Network (You will pay the least)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$25 / visit</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$35 / visit; $25 / chiropractor visit; $35 / acupuncture visit</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.optumrx.com">www.optumrx.com</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Generic drugs</td>
<td>30-Day Supply Retail Pharmacy Tier 1: $10 Copayment 90-Day Supply Mail Order Pharmacy Tier 1: $20 Copayment</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>30-Day Supply Retail Pharmacy Tier 2: $30 Copayment 90-Day Supply Mail Order Pharmacy Tier 2: $60 Copayment</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>30-Day Supply Retail Pharmacy Tier 3: $50 Copayment 90-Day Supply Mail Order Pharmacy Tier 3: $100 Copayment</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>All drugs are covered in Retail Pharmacy and Mail Order Pharmacy Tiers 1 – 3</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$250 / admission</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>-------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency room care</td>
<td>In-Network (You will pay the least)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$150 / visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 / visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$350 / admission</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$25 visit</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$350 / admission</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$350 / admission</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network (You will pay the least)</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$25 / visit for outpatient services; $350 / admission for inpatient services</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$25 / visit</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$350 / admission</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>$25 / visit</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No charge</td>
</tr>
</tbody>
</table>
### Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
</table>
| - Children’s glasses  
- Cosmetic surgery  
- Dental care (Adult)  
- Long-term care  
- Non-emergency care when traveling outside the U.S.  
- Private-duty nursing |

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
</tr>
</thead>
</table>
| - Acupuncture (20 visits per calendar year)  
- Bariatric surgery  
- Chiropractic care (12 visits per calendar year)  
- Hearing aids ($2,000 per ear every 36 months)  
- Infertility treatment  
- Routine eye care - adult (one exam per calendar year)  
- Routine foot care (only for patients with systemic circulatory disease)  
- Weight loss programs ($150 per calendar year per policy) |
Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform and the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Your state insurance department might also be able to help. If you are a Massachusetts resident, you can contact the Massachusetts Division of Insurance at 1-877-563-4467 or www.mass.gov/doi. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596. For more information about possibly buying individual coverage through a state exchange, you can contact your state’s marketplace, if applicable. If you are a Massachusetts resident, contact the Massachusetts Health Connector by visiting www.mahealthconnector.org. For more information on your rights to continue your employer coverage, contact your plan sponsor. (A plan sponsor is usually the member’s employer or organization that provides group health coverage to the member.)

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call 1-800-782-3675 or contact your plan sponsor. (A plan sponsor is usually the member’s employer or organization that provides group health coverage to the member.)

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Disclaimer: This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network prenatal care and a hospital delivery)

- The plan’s overall deductible: $0
- Delivery fee copay: $0
- Facility fee copay: $350
- Diagnostic tests copay: $0

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**Total Example Cost**: $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost sharing</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>10</td>
</tr>
<tr>
<td>Copayments</td>
<td>400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $60

**The total Peg would pay is**: $470

The plan would be responsible for the other costs of these EXAMPLE covered services.

### Managing Joe’s Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: $0
- Specialist visit copay: $35
- Primary care visit copay: $25
- Diagnostic tests copay: $0

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Durable medical equipment (glucose meter)

**Total Example Cost**: $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost sharing</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>100</td>
</tr>
<tr>
<td>Copayments</td>
<td>1,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $20

**The total Joe would pay is**: $1,320

### Mia’s Simple Fracture
(in-network emergency room visit and follow-up care)

- The plan’s overall deductible: $0
- Specialist visit copay: $35
- Emergency room copay: $150
- Ambulance services copay: $0

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

**Total Example Cost**: $2,800

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost sharing</th>
<th>$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>0</td>
</tr>
<tr>
<td>Copayments</td>
<td>300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $0

**The total Mia would pay is**: $300

The plan would be responsible for the other costs of these EXAMPLE covered services.